FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: *Commonwealth of Virginia*
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date: _____

Reporting Period: *FFY99*

Contact Person/Title: *Kathryn T. Kotula, Director, Division of Policy and Research*

Address: *Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23119*

Phone *804-371-8850* Fax *804-786-1680*

Email *KKOTULA@DMAS.STATE.VA.US*

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

1.1.1 What are the data source(s) and methodology used to make this estimate?

See 1.1.2

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The Virginia Department of Medical Assistance Services (DMAS) was designated by the 1998 General Assembly of Virginia to develop and implement the Virginia Children's Medical Security Insurance Plan (VCMISP). DMAS is the designated Medicaid program under Title XIX of the Social Security Act. The application for federal approval of VCMSIP was submitted to the Health Care Financing Administration in June 1998 by the Secretary of Health and Human Resouces Claude A. Allen. Federal approval was granted on October 22, 1998 and DMAS began accepting applications for CMSIP enrollment on October 26, 1998. The information provided for this required evaluation of the CMSIP program corresponds to the federal fiscal year of October 1998-September 1999 (FFY99).

In the application requesting approval of VCMSIP, the estimated number of uninsured to be served, reflecting a phasing-in of the program, was 36,340 in FFY99, 53,720 in FFY00, and 63,200 in FFY01. DMAS has reviewed these estimates for the purposes of this evaluation and will not be revising them. DMAS is aware that under the current CMSIP program enrolling these numbers of uninsured may take longer than the FFY2001 period. The estimates were based on a 1997 survey for the Virginia Health Care Foundation and census data estimates. While a subsequent survey has been completed as described below, updated census estimates for 1999 are not available.

DMAS continues to find these estimates of the uninsured reliable given the limitations of current survey methods and population estimates. The surveys were conducted by professional survey organizations utilizing standard protocols. The 1999 survey had a sampling error of plus or minus approximately 3.3 percentage points at the 95 percent level of confidence. The Bureau of the Census publishes information on the limitations of census data.

Virginia has made progress in reducing the number of uninsured children over the past decade. A 1993 Virginia Health Access Survey showed that approximately 14 percent of children were uninsured. A similar survey was conducted in 1996 for the Virginia Health Care Foundation resulting in estimates of the number of uninsured children of approximately 12 percent. Estimates by the Children's Defense Fund based on data compiled by the U.S. Census Bureau showed approximately 11 percent of Virginia children to be uninsured in 1996 and 1997. In 1999, the Virginia Children's Health Access Survey was conducted, reporting that approximately 10 percent of Virginia children were uninsured.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

The number of children enrolled in CMSIP over the FFY99 period is 18,948. These are children enrolled anytime during FFY99. CMSIP provided creditable coverage to these children enrolled during this period. During FFY99, DMAS also enrolled approximately 6000 net additional Medicaid children.

1.2.1 What are the data source(s) and methodology used to make this estimate?

This is based on information from the DMAS computer eligibility files for the number of children enrolled in FFY99.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

DMAS finds the count of the number of children enrolled to be reliable, given that this computer file is used to maintain all the eligibility information on CMSIP and Medicaid eligible persons.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

All tables for VCMSIP are at the end of this document.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

x Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: Virginia Children's Medical Security Insurance Plan

Date enrollment began (i.e., when children first became eligible to receive services): October 26, 1998

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.2 What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))

Economic Indicators

Virginia exceeds the national average in many indicators that measure economic health. Household income is $43,354 (state rank of 10th) compared to the national average of $38,885. Personal income per person slightly exceeds the national average ($24,299 compared to $23,436), and the employment per population ratio is 64.2 compared to the national average of 63.8 (US Bureau of Economic Analysis, US Bureau of the Census, US Bureau of Labor Statistics, 1999).

The Poor and the Uninsured

According the to U.S. Census Bureau, in 1996, 11.3% of all Virginians are poor, with 16.5% of those under the age of 18 living in poverty, and 18% of those under the age of five living in poverty. This compares to the national average of 13.7%, 20.5%, and 23.4%, respectively. The recent US Census Bureau Current Population Report states that 14.1% of all Virginians went without health insurance coverage throughout the year in 1998. This compares to 16.3% adults and 15.4% children without insurance nationally.

Employer Sponsored Health Insurance

Virginia has more than 300,000 full-time businesses, of which: 96% have fewer than 100 employees; 76% have fewer than 10 employees; and more than half, 58%, have fewer than five employees (NFIB, 1999). The percentage of Virginia's uninsured adults who are employed full-time has increased from 41% in 1993 to 57% in 1996 (VHCF). Small employers in Virginia have a significantly higher percentage of employees who are uninsured than larger employees. In fact, 51% of the employed adults who are uninsured worked for employers that offered health insurance. The main reason for not participating in employment-based health insurance was the cost of participation (VHCF). This conforms with national statistics that indicate that smaller firms are less likely than larger firms are to offer health insurance to their employees. In 1996, private establishments with 1-25 employees offered health insurance at a rate of 34.5% (1-10 employees) to 64.9% (10-24 employees), compared to larger firms, which offered health insurance 93% (100-999) to 97% (1,000 or more)(Branscome et al, 2000). In 1998, just 29% of employees working in firms with fewer than 25 employees participated in employment-based health insurance, compared to 66-67% of workers in firms with more than 500 employees (US Census Bureau, 1999). Although there are multiple reasons why small firms have a higher rate of uninsured employees (no access to coverage, coverage is considered too expensive), this disparity between small and large firms suggests that not only do fewer small firms offer employment-sponsored health insurance, but also that the participation rate, or "take up," of employer-sponsored health insurance by employees in small businesses is less than by employees in larger firms.

1999 Child Health Access Survey

Virginia Commonwealth University conducted the Virginia Children's Health Access Survey (VCHAS) for the Virginia Department of Health and the Department of Medical Assistance Services in 1999. Survey findings indicate that most of the children in the responding households were covered by some form of health insurance, with 10% of children having no insurance (an estimated 135,000 to 205,000 children statewide reflecting sampling error.). This figure compares with the national average of 15.4% for uninsured children. Nearly two-thirds (64%) of the children in the VCU survey had comprehensive insurance coverage, another one-quarter (23%) had basic insurance coverage, and a few (3%) had "specialty" coverage only. Of the children with health insurance, 68% were covered by a private source of insurance obtained through a parent's job or union. Medicaid covered an additional 15% of children with health insurance. Again, these numbers compare with national averages of 67.5% of children covered by private insurance, and 19.8% of children covered by Medicaid. Respondents who reported annual household earnings of less than $20,000 were more likely to report that their child had no health insurance coverage (23%), as were households with African-American (18%) and older children (16%). Again, this loosely corresponds to the national data on uninsured children by race, with 19.7% of African-American children being uninsured, and 16% of older children lacking health coverage. (Sources: VCHAS, VCU, 1999; US Census Bureau, Current Population Reports: Health Insurance Coverage, 1998).

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

The design of the Virginia Children's Medical Security Insurance Program (CMSIP) was most influenced by the existing

Medicaid Program. This influence is most noticeable and relevant in the areas of enrollment methodologies, services provided and covered, and overall administration of the VCMSIP program.

Medicaid income methodologies are used in determining eligibility for VCMSIP and therefore only higher income standards, status of health insurance coverage or availability, and other non-financial requirements specific to VCMSIP are applied to those applicants who are determined ineligible for Medicaid (State Child Health Plan Section 2.3).

Virginia's Title XXI program offers nearly identical menu of benefits as the Title X1X Medicaid program. There are three exceptions, VCMIPS covers: inpatient mental health services in general acute hospitals rather than institutions for mental disease (IMDs); outpatient substance abuse services and inpatient substance abuse services for pregnant women; and coverage for abortion services is limited to cases in which the physician certifies that the abortion is necessary to save the life of the mother.

Health care services for VCMSIP are provided through the existing managed care delivery systems that were established through the current Medicaid 1915(b) waiver programs (State Child Health Plan Section 3.1). This program also means that VCMSIP enrollees have the same managed care options as those enrolled in Medicaid in their area. These plans include: MEDALLION, Options (a voluntary MCO), and/or MEDALLION II.

Lastly, VCMSIP was created as a separate program in order to afford greater flexibility to design its program within the broad parameters established in the federal legislation. By creating a separate program, the state is able to target specific populations for enrollment into VCMSIP as well as restructure the program over time, as necessary, to include items such as co-payments.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

x No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

The State Medicaid program continues to cover children 0-6 at up to 133% Federal Poverty Level and 6-18 up to 100% FPL. The VCMSIP is not a Medicaid expansion, but rather a stand-alone program to assist children whose families are not eligible for Medicaid benefits because their income exceeds Medicaid eligibility and because of a lack of affordable employment-based health insurance benefits.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

x Changes to the Medicaid program
___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify number of months ___)
___ Elimination of assets tests
x Elimination of face-to-face eligibility interviews
___ Easing of documentation requirements

The introduction of the Virginia CMSIP program had an effect on Medicaid enrollment in the state. A statistical analysis of Medicaid and VCMSIP eligibility files indicate that the introduction of VCMSIP, with its attendant outreach and enrollment efforts, also attracted and enrolled additional children in the state Medicaid program. DMAS estimates this resulted in 6000 net additional Medicaid children.

The Virginia CMSIP program does not provide for presumptive eligibility because the state maintains that the most effective way to enroll eligible children is to assist an applicant in completing a formal application, which will result in a definitive decision about eligibility. Presumptive eligibility is based solely on declaration of income and other eligibility factors without verification, and can lead to confusion, false hopes on the part of families, and administrative burdens for the state.

The VCMSIP program has some eligibility requirements that are distinct from the state Medicaid program. Ineligible populations include: children who are eligible for state employee health benefits because a family member is a state or public agency employee; children who have creditable health insurance; children who have had insurance in the prior 12 months, unless certain "good cause" exceptions are met; and children whose parents fail to cooperate with the Division of Child Support Enforcement in providing information to establish paternity and obtain financial and medical support.

Virginia does not require face-to-face interviews as part of the application process for certification or recertification (also called redetermination) for VCMSIP.

x Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF
(specify)_____

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) ended the automatic link to Medicaid for low-income families who received cash assistance. PRWORA replaced the Aid to Families with Dependent Children (AFDC) program and its entitlement to cash assistance with a block grant called Temporary Assistance for Needy Families (TANF). At the same time, Congress retained the AFDC standards and methodologies as the minimum standards for eligibility for Medicaid for low-income families with children. Nevertheless, this de-linking of cash assistance with Medicaid has led to a decline in national Medicaid enrollment, despite expansions in eligibility and new outreach efforts (S-CHIP). From 1995 to 1997, Medicaid enrollment for low-income families declined nationally by 1.6 million (5.4% for adults and 1.4% for children) (Kaiser Commission on Medicaid and the Uninsured, 1999).

In Virginia, there was a 43% reduction in welfare caseloads in Virginia over the three-year period January 1995 and January 1998, with a 12% reduction in 1998. (Source: US Dept. of HHS: www.acf.dhhs/gov/news/stats/caseload.html *as reported in, Losing Health Insurance: The Unintended Consequences of Welfare Reform, Families USA, 1999)*

_x__ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- x Health insurance premium rate increases.
- ___ Legal or regulatory changes related to insurance.
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market).
- x Changes in employee cost-sharing for insurance.
- ___ Availability of subsidies for adult coverage.
- ___ Other (specify).

Private sector health spending accelerated from 4.8% in 1997 to 6.9% in 1998 (HCFA, National Health Expenditures). For the second year in a row, health care costs will increase into the double digits, with companies seeing increases of 8-10% for the next year. This anticipated increase comes on the heels of a rate increase of 7.8% for 1999, the highest hike in health care costs since the early 1990s. Companies are planning to cover most of the health care cost increases, but some will make employees shoulder at least 25 percent of the expected increase. (BNA - Health Care Expectations: Future Strategy and Direction, Hewitt Associates, 1999).

Most employers are at least somewhat worried about future trends in health care costs and the implications of those cost increases. Of firms responding to one survey, 72% said they are worried that health care costs will increase faster than they can afford, 70% say they are worried they will have to cut back the scope of benefits they offer or the amount they contribute towards health insurance for their workers, and 65% say they are worried they will have to switch health plans because of costs. (Source: Employer Health Benefits, Kaiser Family Foundation and Health Research and Education Trust, Annual Survey, 1999).

The 1996 Medical Expenditure Panel Survey – Insurance Component indicates that in Virginia, the total private-sector premiums and employee contributions were: $1974 (single) and $4,953 (family), with the employee contribution being 23% of premium for single coverage and 32% of premium for family coverage. While the total premium amounts in Virginia paralleled the national average ($1,974 vs. $1,997 for single coverage and $5132 vs $4953 for family coverage), the percentage of employee contribution in Virginia exceeded the national average (23% vs 17% for single coverage and 32% vs 29% for family coverage). In Virginia, 55.4% of private businesses offered health insurance, ranging from 32% in firms with fewer than 10 employees to 94.2% of firms with 1,000 or more employees (Branscome et al, 2000).

Findings from the MEPS-IC confirm that smaller firms are less likely than larger firms to offer health insurance to their employees. Also, employee premium contributions highlight the issue of affordability of insurance once it is offered. Given the concern over lack of children's health insurance coverage and the declining rate of employer-provided insurance in the general population, it is noteworthy that over 95% of Virginia's businesses have fewer than 100 employees, and over 75% have fewer than 10 employees. Job growth in Virginia from 1991 to 1995 was concentrated in firms with fewer than 20 employees. Although not conclusive, this may indicate that rising health insurance rates, coupled with Virginia's greater than average employee premium contributions, could have a negative impact on the numbers of individuals in Virginia who receive and participate in employment-based health insurance. (Sources: Branscome JM et al, Private Employer-Sponsored Health Insurance: New Estimates by State, Health Affairs 19(1):139-147 (January/February 2000); and NFIB State-by-State: Virginia). Given these factors, it is an important public policy objective to help Virginia families to obtain health insurance through the place of employment.

_x_ Changes in the delivery system
- _x_ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- _x_ Changes in hospital marketplace (e.g., closure, conversion, merger)
- ___ Other (specify) _____

In Virginia, there has been a 450% increase in HMO enrollment this decade, representing a market share of 21% in 1996 (VAHMO). However, there is wide disparity across the state, with HMO market share lower in rural regions. For example, in the Tidewater (Norfolk-Virginia Beach-Newport News) and Richmond regions, HMO penetration was 44% and 48.7%, respectively. Alternately, in Southwest Virginia (Roanoke), the HMO penetration rate was only 17.6%. (Source: National Research Corporation's Health Care Market Guide Survey, 1996)

Virginia appears to parallel the nation in the types of hospitals delivering general health care. In Virginia for 1995, distribution of hospital beds by hospital status (non-profit, for-profit, public) was 72.5%, 15.7%, and 11.8% respectively. The 1995 national distribution of hospital beds by hospital status (non-profit, for-profit, public) was 69.8%, 12.2%, and 18% respectively. (Source: AARP State Profiles, 1998). There does not appear to be a great deal of hospital merger and acquisition activity going on in Virginia.

In 1996, Blue Cross and Blue Shield of Virginia converted to a for-profit entity, Trigon. Several bills were passed in the 1996 and 1997 Virginia General Assembly that focused on converting a domestic mutual insurer to a domestic stock insurer, which resulted in explicit requirements for public notice and distribution of public assets during the to-profit conversion process. Federal law requires that proceeds of the sale of a nonprofit company be used for a charitable purpose. In 1997, the Commonwealth Health Research Board was instituted in Virginia to distribute the proceeds of the Blue Cross-Blue Shield conversion via a competitive grant program to increase health research and health services within the Commonwealth of Virginia.

_x_ Development of new health care programs or services for targeted low-income children (specify)_____

The Commonwealth of Virginia's Department of Health offers many programs for low-income children, as do individual health departments around the state. Basic public health services for low-income children include immunizations, flu and pneumonia shots, TB skin testing, nutritional counseling, and a clinic for adolescent health needs. A sampling of other programs offered under the auspices of the Virginia Department of Health include:

- *Virginia Resource Mothers Program, which trains women from the community to mentor pregnant and parenting teens.*
- *A state-wide information and referral helpline that refers callers to private and public providers of a wide range of health and social services for women, infants, and teens.*
- *Newborn Screening Programs for metabolic conditions, sickle cell disease, and hearing loss.*
- *Child Health primary care programs that improve the access of low-income children to comprehensive primary care services.*
- *Early intervention services for children 0-2 years old at risk of developmental delays.*
- *Children's AIDS Network Designed for Interfaith Involvement, a case management of support services for women and their children affected by HIV/AIDS (Virginia Beach).*
- *A statewide Emergency Medical Services program to improve emergency care for critically ill or injured children (funded by the national MCH Bureau and the National Highway Traffic Safety Administration). The funds include training programs for EMS personnel and school nurses, and the distribution of an emergency care chart for schools and day care centers.*
- *Lead-Safe Virginia, a program targeting children 0-6 years of age to prevent lead poisoning from dust in homes that results from lead-based paint. Lead poisoning can lead to reduced IQ, hyperactivity, reduced stature, reduced hearing, and headaches.*
- *Children's Specialty Services (CSS) Program, a state-wide specialized medical-surgical care program for medically indigent handicapped children. CSS field clinics provide local case finding, diagnosis, treatment, and follow-up with hospitalization and surgery at central clinic sites. Specialty services treat various conditions, including: cystic fibrosis; cardiology; diabetes; endocrinological conditions; eye surgery; hemophilia; facial deformities (maxillofacial) including*

speech therapy evaluation, dental, orthodontic, and prosthodontic treatment; neurological conditions; neurosurgical pathologies (e.g. spina bifida, hydrocephalus, tumors, craniosynostosis, etc.); orthopedics; cerebral palsy; plastic surgery; juvenile rheumatoid arthritis; sickle cell disease; and urology.

- *Child Health Investment Partnership (CHIP), a public-private program for low-income children through the age of six. CHIP provides case management services for comprehensive primary care services (including dental) for children.*
- *School-based health initiatives include: special education health services; procedures and exemptions for administering medication to students; and educational programs for teachers, parents, and children to promote the successful management of asthma (Source: The Virginia Department of Health; Health Policy Tracking Service Issue Brief entitled, Medicaid and Indigent Care: School-Based Health Centers, 1999).*

Another example of an entity that offers new health care programs or services for low income children is The Virginia Health Care Foundation. This is a private, not-for-profit foundation that leverages public dollars with private sector resources in order to increase access to primary health care for Virginia's uninsured and medically underserved. The 1999 VHCF programs that target low-income children include:

- *Arlandia Health Center: Primary and preventive care for medically indigent Hispanic women and children.*
- *INOVA Health System: School-based initiative linking uninsured children with available health insurance.*
- *INOVA Health System: Establishment of a primary care medical practice for 2,200 children, combining volunteer and paid physicians.*
- *Bedford Community Health Foundation: Dental care and education for indigent children through a school-based dental trailer.*
- *Blue Ridge Medical Center: Providing "insurance passports" for uninsured residents for $25/year.*
- *Buckingham County Rural Mental Health Initiative: Mental health services for children and adults with uncomplicated psychiatric disorders.*
- *CHIP of Richmond: Case management for targeted children with asthma and primary health care services and case management for more than 200 Richmond children.*
- *Accomack County Schools: Expanded school-based dental program.*
- *Eastern Shore Rural Health Systems: Expand pediatric facility and addition of pediatric nurse practitioner.*
- *Northern Neck CHIP/Health Families: Comprehensive case management for at-risk and developmentally delayed children and their families in Lancaster, Northumberland, Richmond, and Westmoreland counties.*
- *CHIP/Healthy Families of Chesapeake: Integration of the CHIP and Healthy Families programs to provide case management to at-risk families.*
- *Norfolk Resource Mothers EVMS: Case management and support for at-risk pregnant women and their infants.*
- *Williamsburg Olde Towne Medical Center: Dental equipment and part-time dentist to expand patient capacity of volunteer dental program.*

- *Roanoke Valley Community-Based Health Care Coalition: Support to establish a pediatric dental practice to serve low income and underserved children .*
- *Roanoke Valley Computerized Teen Wellness Program of VA Tech: Interactive software to improve the health behaviors of high school students.*

(Source: Virginia Health Care Foundation, 1999 Annual Report)

_x_ Changes in the demographic or socioeconomic context

___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____

___ Changes in economic circumstances, such as unemployment rate (specify) _____

_x_ Other (specify) *Population changes*

_x_ Other (specify) *Insurance changes*

In 1998, the population of Virginia was 6,853,704 persons, of which 1,739,000 are children (approximately 24%, the same percentage as in 1990). Virginia ranks 10th in the nation in household income (falling two places from 8 in 1990), ranks 13th in personal income per person (and held the same rank in 1990), with an employment/population ratio that exceeds the national average (64.2 versus 63.8). Like the rest of the nation, Virginia is enjoying economic growth, with a stable (2 year) unemployment rate of around 3.0%. (Source: AARP State Profiles, 1998; U.S. Bureau of Labor Statistics, 1998; Virginia Economic Indicators, 1999).

While it is encouraging that the percentage of uninsured Virginia children has declined somewhat from the 1993 survey to the 1999 survey (14% and 10%, respectively), another change has occurred as well. The 1993 health access survey found that 74% of children were covered by a comprehensive health insurance plan while in 1999 this decreased to 64%. While the 1999 survey shows a decrease in comprehensive coverage, there appears to be an offset with an increase in basic or specialty coverage, although the analysis notes this may be due to differences in the wording of the survey questions. (Results from the 1999 Virginia Children's Health Access Survey, draft copy).

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

See Table 3.1.1.

3.1.2 How often is eligibility redetermined?

See Table 3.1.2.

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

___ Yes ° Which program(s)?

For how long?

__*x*__ No.

Recipients are required to report changes in income (and children living in the household) when the changes occur. Eligibility is recalculated each time there is a reported change.

3.1.4 Does the CHIP program provide retroactive eligibility?

___ Yes ° Which program(s)?

How many months look-back?

__*x*__ No.

The effective date of coverage shall be no earlier than the first day of the month in which the application was received by the local Department of Social Services if the applicant met all eligibility factors in that month.

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ° Which program(s)?

Which populations?

Who determines?

__*x*__ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

__*x*__ Yes ° Is the joint application used to determine eligibility for other State programs?

No, just the Medicaid Program.

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

The eligibility determination process begins once the local Department of Social Services receives the completed application. The child must be less than 19 years of age, is not currently covered under a health insurance plan, has suitable identification requirements (i.e., birth certificate, Social Security number, etc.), among other requirements. Upon receiving the application, all requirements are checked that they have been met before proceeding with coverage for the applicant. If the application is in order, coverage will begin on the first day of the month that the application was made (Virginia Medicaid: VCMSIP Handbook).

Strengths

Several areas of the application process and eligibility determination aid the targeted population in obtaining medical coverage for their children. First, the VCMSIP application is a double-sided, one-page joint application for VCMSIP and Medicaid. This joint application serves to evaluate those who qualify for Medicaid as well as for VCMSIP. This is helpful because some applicants may not be aware that their children are eligible for Medicaid, particularly since the reform of the welfare system when Medicaid was de-linked from cash assistance. As mentioned earlier in this report, the changes in the welfare system culminated in greater numbers of children being uninsured, some of whom are still Medicaid eligible. The length of the application is also a great strength of the VCMSIP eligibility determination. By limiting the application to one double-sided page, applicants may not see the process as burdensome and time consuming.

The lack of a requirement for a personal interview in order to complete the application process also serves as a strength of the VCMSIP eligibility determination. The target population is children of working families. By not requiring interviews, the applicants will be able to complete the application and deliver it or mail it to their local DSS office (or other VCMSIP site), without having to take time off from work.

Finally, flexibility in the application process has promoted joint public and private outreach efforts help to "spread the word" about VCMSIP. Some examples of private and public outreach efforts include:

- *Virginia Poverty Law Center – Over 1,000 community workers trained to help families apply for CMIP. (Nablo and Barker – Enrolling Virginia's Uninsured Children).*
- *Children's Hospital of the King's Daughters – Entering into partnerships with the business community to reach out to working families. (Nablo and Barker).*
- *Partnerships with Medical Associations and Facilities – Partnerships with Medical College of Virginia Hospitals, Virginia Health Nurses Association, Albemarle County Medical Association, and Kroger pharmacies (Quarterly Report on V-VCMSIP July 1-September 30, 1999).*

It is through the efforts listed above, as well as the numerous other outreach efforts currently underway that DMAS plans to increase enrollment in the target population.

Weaknesses

While the VCMSIP application and eligibility determination do have their strengths, there also are some weaknesses in the program. First, while the application is only one (double-sided) page long, the print is very small and some of the language may be too complex for some of the applicants.

Second, the assignment of support rights in the application is often viewed as a barrier to enrollment. In some cases, the applicant may not have the information requested for support rights, may have an on-going informal financial relationship with the absent parent, or may not want them involved in the life of the child (UVa Study).

Third, in some cases verification of information may be too burdensome to collect. Applicants may not have the information or know where to go for the verification information.

Fourth, the eligibility determination process is decentralized to the locality level. This has resulted in some inconsistencies in the length of the eligibility determination process.

Fifth, DMAS has an ongoing concern that families with an employed parent need to access the welfare system to obtain health insurance.

Finally, many applicants may need assistance in completing the application. This suggestion is borne out by the large number of applications that are never completed because of a "failure to provide information." Although one of the strengths of the VCMSIP application is the increased access to the program with the removal of the requirement for a face to face interview, this aspect may also be a weakness. Some applicants may choose not to follow-up with their local DSS office when they have questions and ultimately end up with incomplete applications that are denied because of the time limit or they were unclear about how to collect all of the required documentation.

However, despite the evidence that applicants may need assistance in completing the application, it is not known how many individuals actually need this service, and when asked, many applicants assert that they do not need help. This suggests that the large number of incomplete applications may also have something to do with the "hassle factor" of completing the application rather than a lack of understanding about the process. (UVA Survey, 1999).

3.1.7 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The strengths and weaknesses of the eligibility redetermination process are very similar to the ones listed above for eligibility determination.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

See Table 3.2.1.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

The Commonwealth of Virginia provides children's health services under the VCMSIP program, which parallel the benefits under the current Medicaid program. There are three exceptions to this in that VCMSIP covers: inpatient mental health services in general acute hospitals rather than institutions for mental disease (IMDs); outpatient substance abuse services and inpatient substance abuse services for pregnant women; and coverage for abortion services is limited to cases in which the physician certifies that the abortion is necessary to save the life of the mother.

The VCMSIP is coordinated with the Virginia Department of Health including Children's Specialty Services and the Maternal and Child health programs, state teaching hospitals serving indigent families, and local government health delivery programs which serve low-income children. Children with special needs are also served by Virginia agencies and organizations under Part B and Part C of the Individuals with Disabilities Education Act.

Covered preventive, primary, and acute services include: inpatient and outpatient hospital care; physician's services; surgical services; psychiatric and psychological services (inpatient and outpatient); substance abuse services; laboratory and radiological services; prescription drugs and some over-the-counter drugs as prescribed by a physician; home health services including physical, occupational, and speech/language therapies; clinic services; early and periodic screening, diagnosis and treatment (EPSDT) services (immunizations, physical examinations, eye and hearing tests, laboratory tests, dental check-ups, other services); podiatry services; dental care services; pre-pregnancy family-planning services (does not include fertility services); medical transportation; hospital emergency room treatment; durable medical supplies and equipment; eye examinations and eyeglasses; diabetes self-monitoring kits; rehabilitation services; prosthetic devices; case management services; expanded prenatal services; hospice services; community mental health services; and organ transplants. Abortions are not covered unless necessary to save the life of the mother.

DMAS covers some "enabling" activities. DMAS reimburses non-emergency transportation to covered medical services. Outreach is described in section 3.5.

VCMSIP enrollees have the same three regional managed care program options as the Medicaid eligibles in their area: i.e., MEDALLION, Options, or Medallion II, the mandatory MCO Program. State Child Health Plan, Section 3.1 (B) (page 3-1) Since managed care's inception in 1993-94 DMAS has developed several internal and external quality assurance programs, initiated as part of the federal 1915(b) waiver programs, and which apply to VCMSIP. This assures that VCMSIP members will receive the same quality of and access to care currently provided to Virginia's Medicaid managed care members. Access and quality of care activities are described at Section 4.4.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

See Table 3.2.3.

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

_X_ ***No cost sharing initially.*** *No, skip to Section 3.4.*

___ No, skip to Section 3.4

___ Yes, check all that apply in Table 3.3.1

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
___ Family
___ Absent parent

___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify) _____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

See Table 3.4.1.

3.4.2 *Where does your CHIP program conduct client education and outreach?*

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

See Table 3.4.2.

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

The state has utilized focus groups, call center data, presentation evaluations, and a public relations firm (Cahoon and Cross) to evaluate media effectiveness.

Outreach effectiveness is evaluated by the current enrollment numbers, call center statistics, and feedback from two workers, evaluations of presentations, along with survey questions. Implementation of a second evaluation by Cahoon and Cross is under negotiation.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

The CMSIP brochure and application have been translated into Spanish. The CMSIP call center has added live operators speaking Spanish and all automated prompts are in English and Spanish. All calls are recorded in a database format including names, phone numbers address, and type of information given.

A language line component is being researched as an addition to the existing structure to allow access to over 100 languages, including Chinese, French, Japanese, Korean, Russian, Vietnamese, Armenian, Cambodian, German, Haitian Creole, Italian, Polish, Portuguese, Farsi, Thai, Tagalog, and Urdu.

In addition, outreach partnerships have been made with community organizations that reach out to ethnic constituents.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

The outreach strategies that have been the most effective pertain to face-to-face interaction. One-on-one facilitation of the program has proven highly effective. In addition, community involvement is key, as well as the outreach worker being a trusted member of the community. For these reasons, the RWJ pilot programs have been crucial to developing community specific strategies for one-on-one enrollment facilitation.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

See Table 3.5

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

_x_ Eligibility determination process:

_x_ Waiting period without health insurance (specify) *12-month waiting period for children previously insured*

_x_ Information on current or previous health insurance gathered on application (specify*) The parent must provide documentation as to the reason the child's previous health insurance coverage was discontinued within the past 12-months.*

___ Information verified with employer
___ Records match (specify)
x Other (specify): *Declaratory statement described below*
___ Other (specify)

As part of the application for the VCMSIP, each application includes a declaratory statement that the child for whom the application is being filed is not covered under any group health insurance plan. The application includes a question about health insurance in the past. If the child has been covered under a health insurance plan within the past 12 months, the child is ineligible for VCMSIP, unless the reason for dropping the coverage is approved by the state.

The 12 month waiting period is not intended to discourage application for CMSIP but rather to insure that the publicly subsidized program is not substituting for or contributing to the erosion of private health insurance coverage.

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

The Department of Social Services reports case denial information for VCMSIP , which includes insurance status, to the Department of Medical Assistance Services. DMAS officials monitor this information.

Virginia's waiting period of twelve months of being uninsured after participating in employment-based health insurance is the maximum waiting period allowed by the federal government. The general 12-month period of ineligibility can be waived if a family claims "good cause" for the discontinuation of a child's health insurance coverage and documents that the health insurance was discontinued for specific reasons.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

Table 4.1.1 has data for VCMSIP from the HCFA quarterly reports in FFY99. DMAS has experienced problems with interpreting the HCFA definitions and instructions for counting the children for these reports. DMAS maintains that the inconsistent HCFA reporting mechanism is the source of these difficulties. DMAS has unresolved issues with counting children which has affected the computer programs such as for counting the number of children for the year end. DMAS is working on resolving these matters.

For the purposes of this evaluation, DMAS has identified those children enrolled in VCMSIP anytime in FFY99 from the computer eligibility files. The results of this are that 18,948 children were enrolled in VCMSIP in FFY99. The racial distribution of VCMSIP enrollees was: 57.8% white; 27.7% black; 10.9% Hispanic; 3.2% Asian; 0.1 % Native American; and 0.2% other. Males were 50.3 percent of the enrollees, and females 49.7% of the enrollees. The average age on day of VCMSIP enrollment was 9.2 years. The average length of enrollment was 4.8 months in FFY99. By comparison, the average length of enrollment for Medicaid children varies considerably depending on the eligibility group but is anywhere from less than a year to over two years. Approximately 33.1% of the children were enrolled in the Medallion program, 20.8% in Medallion II and 33.1% under fee-for-service. The age of the children and poverty level were distributed as follows:

	Age <1	*Age 1-5*	*Age 6-12*	*Age 13-18*	*Total*
150% poverty or less	*230*	*1755*	*7079*	*3755*	*12,819*
More than 150% poverty	*287*	*1996*	*2405*	*1441*	*6129*
	517	*3751*	*9484*	*5196*	*18,948*

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

The Department of Medical Assistance Services contracts with an enrollment broker which serves the Medicaid and CMSIP populations, to assist families in signing-up. The broker asks the CMSIP enrollees a series of questions including about their prior access to the health care system. Of the almost 6000 CMSIP persons analyzed, 4072 had no prior health insurance coverage in the previous 12 months and 1,444 had prior Medicaid coverage but not in the previous 12 months.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Virginia currently does not have a high risk pool or health insurance purchasing cooperatives (HIPCs) to increase the availability of health insurance for families and children. Although the Commonwealth of Virginia studied the possibility of creating a HIPC, the research suggested that HIPCs function best in a small group market that requires the same modified community rating techniques inside and outside of the HIPC. Virginia has no standardized modified community rating requirements. Instead, Virginia utilizes "Open Enrollment" carriers in the individual health insurance market, which must issue coverage without the imposition of underwriting criteria. There are two "open enrollment" carriers in Virginia (Trigon BlueCross BlueShield and BlueCross BlueShield of the National Capital Area). The open enrollment program provides a source of coverage to many persons who otherwise would not be able to purchase coverage elsewhere in the market – almost 21,000 individuals in 1997. While the rates for these types of individual policies are higher than other individual policies they are lower than if they were subject to medical underwriting. In return, the Commonwealth imposes a lower premium tax on these carriers to offset any plan losses that result from insuring person with costly or high risk medical conditions. (Source: JCHC, Issue Brief 16, 1999).

The percent of children covered by Medicaid or other public-sector health insurance in 1996 was 26% in Virginia, compared to the national average of 25%. As reported above in 2.2.3, there was a 43% reduction in welfare caseloads in Virginia over the three year period January 1995 and January 1998 with a 12% reduction in 1998. This parallels the national phenomenon of increasing the numbers of uninsured children as a result of welfare reform and the delinking of Medicaid from cash assistance. Indeed, this is one reason the SCHIP program was initiated and the intent of the new federal/state program included capturing some of the children who were Medicaid eligible but currently uninsured in the outreach and enrollment process for SCHIP. Many states have seen their Medicaid enrollment rolls increase along with their SCHIP enrollments, and Virginia is no exception: since federal approval of the VCMSIP program, nearly 25,000 additional children in Virginia now have health insurance, of which 6,000 net additional are enrolled in the Medicaid program for FFY99.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

The number of disenrollees (eligibility cancellations) for FFY99 is 3,085 using a count of children on the DMAS eligibility computer file. The number of disenrollees is 3,671 using the HCFA quarterly reports submitted by DMAS. The HCFA quarterly reports have some children disenrolling more than once. Based on a comparison with the Medicaid population the percent disenrollment is lower for the CMSIP population (15.6%) than for the Medicaid population 18 years of age and younger (30.1%).

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

Although the Virginia CMSIP program began in October of 1998, the bulk of enrollments did not begin until 1999. In mid-December 1998 there were 1107 children enrolled in the program, 6,088 by mid-March 1999, and almost 15,000 by the end of September 1999. Therefore, the redetermination process has really just begun, and currently there is no data to report.

Among the reasons for discontinuation of coverage for VCMSIP enrollees approximately 370 were due to other insurance coverage.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

See Table 4.2.3. This FFY99 data is from the eligibility computer files. The categorical descriptions do not correspond in all cases with the National Academy for State Health Policy categories.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Various approaches are used for these children. HMOs perform targeted mailings to those individuals who lose eligibility to let them know that they still could be eligible for coverage. Postcards are mailed to people identified as having lost their eligibility. Advocacy groups try and target in their outreach those individuals who may have lost eligibility. Local Departments of Social Services also have the discretion to follow-up with these children. Also the numerous, ongoing general outreach efforts can encourage children to reenroll.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998: *NA*

FFY 1999: *$7,550,140*

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services? *For FFY99, approximately $825,000 was spent on HMO capitation payments and $6,264,000 on direct services.*

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? *Activities included outreach, eligibility determination, and contractual services.*
The Department of Social Services is spending the largest portion of the administrative expenses. This is for activities such as outreach and eligibility determination. DMAS has paid most of its administrative expenditures from State funds to manage within the 10% cap on administrative expenses. DMAS plans to reimburse the Department of Social Services its matching federal funds after it has been determined that they will not exceed the 10% cap. DMAS has received expenditure billings from DSS for FFY99 of approximately $1,267,000.

What role did the 10 percent cap have in program design*? It clearly set an upper limit on administrative expenditures which the state had to work within.*

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

- *X* State appropriations
- ___ County/local funds
- ___ Employer contributions
- *X* Foundation grants
- ___ Private donations (such as United Way, sponsorship)
- *X* Other (specify) special funds from General Assembly

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

See Table 4.4.1.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

See Table 4.4.2.

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Currently available information on access to care includes reports on network capacity such as on time/distance standards, urgent/routine care standards, and counts of rural providers and other providers. Also analyses on disenrollments. Recipient surveys have information on items such as medical appointment availability. The household survey report has information on access and quality measures. DMAS and the HMOs track complaints and grievances and DMAS tracks appeals. DMAS has draft reports on immunizations and prenatal care. DMAS Surveillance and Utilization Review Subsystems reports address those persons who have low and/or high utilization of services.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

Information available for the future on access to care includes case file reviews for the purposes of encounter data validation. DMAS Surveillance and Utilization Review Subsystems reports will be assessing that primary care practitioners are meeting contractual obligations such as under EPSDT. This information should be available by the end of 2000 with the exception of encounter data available at the end of 2001.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

See Table 4.5.1.

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Currently available information on quality of care includes immunization and prenatal care draft reports, the household survey report on access and quality measures, DMAS Surveillance and Utilization Review Subsystems reports on low and high utilization of services, complaint and appeals tracking reports, and *enrollment broker disenrollment reports. DMAS also has numerous quality of care process activities such as the DMAS Quality Assurance Workgroup and the Case Managers' Meetings which are discussed on Table 4.5.1*.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Information available in the future on quality of care includes SURS reports on primary care practitioners meeting contractual obligations such as under EPSDT; client satisfaction surveys; case file information from encounter data validation, HEDIS measures for comparison of HMOs, with Medallion and fee-for-service; and an independent assessment of the Medallion II waiver for 1998-99. With the exception of the encounter data, the information should be available by the end of 2000. Encounter data information should be available by the end of 2001.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

See page 34 for a listing of documents.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment- *The importance of simplifying as much as possible the eligibility criteria and the eligibility process. In addition, an awareness that the welfare stigma of CMSIP can serve as a barrier to enrollment.*

5.1.2 Outreach- *This needs to have a broad community base by involving as many organizations a possible. Also a broad array of strategies is necessary to inform potential enrollees.*

5.1.3 Benefit Structure- *The benefit structure needs to be comprehensive because this is ultimately what is attracting potential enrollees to the program. Also the benefit structure should be comparable to what is in the private sector to move away from the welfare stigma of the program and also to encourage participation by the private sector.*

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)- *NA*

5.1.5 Delivery System- *This needs to parallel as much as possible what is found in the private sector because these systems are already in place and familiar to both the enrollees and those delivering the services.*

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)- *DMAS has coordinated with public, not-for-profit, and for-profit firms in the development and implementation of VCMSIP. DMAS continues to work with these organizations as to common programmatic interests for meeting the health insurance needs of low-income children.*

5.1.7 Evaluation and Monitoring (including data reporting)- *These systems take time to develop especially in the months involved with start-up of the program. Never-the-less they are essential to effective program management and allowing for a high quality of services for the enrolled population.*

5.1.8 Other (specify)

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

The year 2000 session of the Virginia General Assembly, the legislative body of the Commonwealth of Virginia, enacted legislation to revise child health insurance coverage under Title XXI. Features of these changes include:

- *Coverage of eligible children from birth through age 18 in families with income at or below 200% of the federal poverty level.*
- *Simplified eligibility determination is based on gross income.*
- *Centralized eligibility processing will reduce length of application process.*
- *Comprehensive benefits including well-baby and preventive services.*
- *Health care delivery through the centralized system will utilize commercial insurance programs or other DMAS authorized entities.*
- *Subsidizes health insurance premiums of eligible children with access to employer-sponsored insurance, which may enable coverage of entire families.*
- *Children who do not have access to employer-sponsored insurance will be covered directly under the state-administered plan through private insurers, health care providers or HMOs.*

DMAS staff is currently working on regulations and other activities to implement these changes.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

Virginia continues to support legislative changes to Title XXI which allow states greater flexibility in the design and implementation of health care coverage for low-income children.

Supplemental documents provided by DMAS:

1. *Managed Care Complaint Reports, December 1999.*

2. *Department of Medical Assistance Services HMO Hospital Network Analysis Central Virginia Medallion II Expansion Effective April 1, 1999.*

3. *Department of Medical Assistance Services HMO Practitioner Network Analysis Central Virginia Medallion II Expansion Effective April 1, 1999.*

4. *HMO Participating Provider Network Information Areas Adjacent to Central Virginia Medallion II Expansion.*

5. *Zip Codes Meeting the Access Standard.*

6. *Quality Assessment and Improvement Project for Medicaid Managed Care in Virginia, 1999.*

7. *Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program [four reports for October 1998-September 1999].*

Sources

1. Agency for Health Care Policy and Research, *Learning from CHIP I and Learning from CHIP II.* February 1999. http://www.ahcpr.gov/about/cods/codschip.htm

2. Agency for Health Care Policy and Research, Center for Cost and Financing Studies, 1996 *Medical Expenditures Panel Survey – Insurance Component*, By Firm Size and By Division and State, Percent of Employees in Firms that offer Insurance (Table 2G) and Percent of Private Sector Employees Eligible for Health Insurance (Table 2H).

3. American Association of Health Plans, *Small Business and Health Plans*, September 1998.

4. American Association of Retired Persons, *Reforming the Health Care System: State Profiles 1998*, AARP, Washington, D.C., 1998

5. American Public Human Services Association, *CHIP Outreach and Enrollment: A View from the States*, June 1999.

6. Annie E. Casey Foundation, 1999 KIDS COUNT Data Online, Trend Data: Virginia and the U.S., http://www.aecf.org/kidscount/kc1999/news3.html, 1999.

7. Branscome J.M. et al (2000), Private Employer-Sponsored Health Insurance: New Estimates by State, *Health Affairs* 19(1)(January-February 2000):139-147.

8. Bureau of National Affairs. *CHIP Program Evolves, Expands; Challenges Still Need to Be Resolved*. July 19, 1999. Volume 7, No.29, pp 1182-1184.

9. Bureau of National Affairs, *Health Care Costs Projected to Climb into Double Digits in 2000, Hewitt Predicts*, November 11, 1999, Vol. 7, No. 45, p. 1817.

10. Bureau of National Affairs, *CHIP Benefits Could Prompt Employers to Drop Coverage for Kids*, June 7, 1999, Vol. 7, No. 23, p. 941-942.

11. Center on Budget and Policy Priorities, Employed But Not Insured: *A State by State Analysis of Low-Income Working Parents Who Lack Health Insurance*, February 1999.

12. Center on Budget and Policy Priorities, *Steps States Can Take to Facilitate Medicaid Enrollment of Children*, http://www.cbpp.org/12-6-99health.htm, December 6, 1999.

13. Clark, Susan L. *Implementation of CMSIP from the perspective of local departments of social services.* Presentation by to the Joint Commission on Health Care, July 27, 1999.

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Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here and indicate who you passed it along to. Name *Jeff Nelson (DMAS)*, phone/email *804-371-8857, JNELSON@DMAS.STATE.VA.US*

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups ____Gross __*x*_Net ____Both

Title XXI Medicaid SCHIP Expansion ____Gross ____Net ____Both

Title XXI State-Designed SCHIP Program ____Gross __*x*_Net ____Both

Other SCHIP program_____ ____Gross ____Net ____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups *133%* of FPL for children under age ___*6*____

100% of FPL for children aged __*6-19*_____

____% of FPL for children aged _____

Title XXI Medicaid SCHIP Expansion *____% of FPL for children aged* _____

____% of FPL for children aged _____

____% of FPL for children aged _____

Title XXI State-Designed SCHIP Program _*185*% of FPL for children aged *birth through age 18*

____% of FPL for children aged _____

____% of FPL for children aged _____

Other SCHIP program_____ ____% of FPL for children aged _____

____% of FPL for children aged _____

____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household	*child, siblings, legally responsible relatives*		*child, siblings, legally responsible relatives*	
All relatives living in the household	*no*		*no*	
All individuals living in the household	*no*		*no*	
Other (specify)				

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded. ***Enter "C" for counted, "NC" for not counted and "NR" for not recorded.***

Table 3.1.1.4

Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings Earnings of dependent children	*C*		*C*	
Earnings of students	*Full-time student-excluded for six months.* *Part-time student and working part-time-excluded.* *Part-time students employed full-time excluded for six months*		*Full-time student-excluded for six months.* *Part-time student and working part-time- excluded.* *Part-time students employed full-time excluded for six months*	
Earnings from job placement programs	*Excluded for six months*		*Excluded for six months*	
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	*NC*		*NC*	

Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	*NC*		*NC*	
Education Related Income Income from college work-study programs	*NC*		*NC*	
Assistance from programs administered by the Department of Education	*NC*		*NC*	
Education loans and awards	*NC*		*NC*	
Other Income Earned income tax credit (EITC)	*NC*		*NC*	
Alimony payments received	*first $50 not counted*		*first $50 not counted*	
Child support payments received	*first $50 not counted*		*first $50 not counted*	
Roomer/boarder income	*Net income counted*		*Net income counted*	
Income from individual development accounts	*NC*		*NC*	
Gifts	*first $30 each quarter not counted*		*first $30 each quarter not counted*	
In-kind income	*NC unless is food and clothing totally supplied on a regular basis for a member of a family unit*		*NC unless is food and clothing totally supplied on a regular basis for a member of a family unit*	
Program Benefits	*NC*		*NC*	

Welfare cash benefits (TANF)				
Supplemental Security Income (SSI) cash benefits	*NC*		*NC*	
Social Security cash benefits	*C*		*C*	
Housing subsidies	*NC*		*NC*	
Foster care cash benefits	*NC*		*NC*	
Adoption assistance cash benefits	*NC*		*NC*	
Veterans benefits	*C*		*C*	
Emergency or disaster relief benefits	*NC*		*NC*	
Low income energy assistance payments	*NC*		*NC*	
Native American tribal benefits	**		**	
Other Types of Income (specify)				

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

** Funds distributed to or held in trust for members of an Indian tribe under Public Laws 92-254, 93-134, 94-540, 98-64, 98-123, 98-124, 97-458 are not counted.

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _x___ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	*first $90 of earned income*	$	*first $90 of earned income*	$
Self-employment expenses	*business expenses*	$	*business expenses*	$
Alimony payments Received	*disregard first $50 monthly*	$	*disregard first $50 monthly*	$
Paid	*NA*	$	*NA*	$
Child support payments Received	*disregard first $50 monthly*	$	*disregard first $50 monthly*	$
Paid	*NA*	$	*NA*	$
Child care expenses	*	$	*	$
Medical care expenses	*NA*	$	*NA*	$
Gifts	*$30 per quarter*	$	*$30 per quarter*	$
Other types of disregards/deductions (specify)	*$*	$	*$*	$

* Full-time employment up to $75 per month for child age 2 or older; disregard up to $200 per month child under 2; and part-time employment up to $120 per month per child.

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	_x__No	____Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	____No	____Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	_x__No	____Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	____No	____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State-designed SCHIP Program (C)	Other SCHIP Program* (D)
Countable or allowable level of asset/resource test	$	$	$	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*				
What is the value of the disregard for vehicles?	$	$	$	$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*				

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes _x_ No

TABLES FOR THE EVALUATION (UNDER TITLE XXI) OF VIRGINIA'S CMSIP PROGRAM IN FFY99

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
To reduce the number of uninsured children.	*Increase the number of Medicaid eligible children enrolled in Medicaid.*	Data Sources: *DMAS eligibility computer file* Methodology: *Tracking the increase in the number of children enrolled in Medicaid* Progress Summary: *This shows a net increase of about 6000 Medicaid children in FFY99.*
	Enroll 63,200 children in VCMSIP by June 30, 2001	Data Sources*: DMAS eligibility computer file* Methodology: *Count VCMSIP participants on file* Progress Summary: *Approximately 18,948 children enrolled in VCMSIP for FFY99. The State still expects to meet the goal of enrolled children but it may take a longer period of time*
	Reduce percentage of uninsured children	Data Sources: *Periodic statewide child health access surveys* Methodology: *Survey conducted that asks about child's health insurance status* Numerator: *Children uninsured* Denominator: *Total children* Progress Summary: *A 1993 statewide survey showed 14 percent of children uninsured. A statewide survey conducted in 1996-97 showed 11 percent of children uninsured. A statewide*

Table 1.3		
		survey in 1999 showed 10 percent children uninsured. Surveys further discussed in 1.1 narrative.
OBJECTIVES RELATED TO CHIP ENROLLMENT		
To conduct effective outreach to encourage enrollment in health insurance plans	*Obtain the active participation of community-based organizations*	Data Sources*: Administrative records of outreach campaign* Methodology: *Contacts tracked with all entities involved in outreach* Progress Summary: *Broad-based outreach campaign including state agencies, all licensed and temporary day care facilities, grocery stores, pharmacies, restaurants, hospitals, schools, Head Start programs, retail stores, non-profits such as United Way, Action Alliance for Virginia's Children and Youth, and other organizations. DMAS sponsored training sessions for these organizations on CMSIP. Virginia was also awarded a Robert Wood Johnson Foundation grant to enable the CMSIP program further active participation by community-based organizations. RWJ – CMSIP Covering Kids Program has three pilot regions in Virginia: a faith-based pilot in a metropolitan area of seven cities; a rural health medical center covering three counties; and an inner city medical treatment center for low-income families. Each RWJ pilot program collaborates with other community-based organizations to recruit and train volunteers as Outreach Workers to recruit and enroll eligible children into CMSIP. The Outreach Workers also provide assistance in completing the CMSIP application. The RWJ pilots participate in community events to market and promote participation in CMSIP. The RWJ – CMSIP Program is collaborating with state agencies (DMAS and DSS Programs) and non-profits organizations to simplify the application and to develop an electronic application. The computerized application program is being pilot tested with RWJ Pilots.*
	Utilize various strategies for informing parents about VCMSIP	Data Sources: *Administrative records of outreach campaign* Methodology*: Strategies tracked in outreach campaign* Progress Summary: *DMAS has a contract with the Virginia Department of Social Services*

Table 1.3		
		for outreach services. VDSS has implemented a four tier outreach approach: Federal, State, Local, and Grassroots. The (1) Federal tier includes a partnership with the Health Care Financing Administration and the Department of Agriculture. At the (2) State level, a media campaign has been launched including radio, television, newspaper, outdoor and transit advertising. VDSS has formed partnerships with community-based organizations, faith-based organizations, child advocacy groups, hospitals, free clinics, HMOs, and other agencies. VDSS hosts and coordinates a CMSIP Outreach Coordinating Committee made up of partners and stakeholders to continuously collaborate and improve upon outreach strategies. State outreach workers developed marketing materials in conjunction with a public relations firm. Mail campaigns target the eligible population and local outreach workers and the local Departments of Social Services. The state is a partner with and equips the 122 local Departments of Social Services to conduct outreach. VDSS fosters partnerships between (3) local community based organizations and the local DSS offices to facilitate the enrollment and outreach process. On a grassroots (4) level, volunteer community outreach workers are recruited from churches, schools, and other community agencies. The volunteers are trained on how to outreach to families and enroll eligible children into CMSIP. The volunteers seek eligible children/families through churches, health clinics, school events, community fairs, depot stations, libraries, Head Start programs and day care centers. The RWJ-CMSIP pilot programs are recruiting and training lay volunteers to do outreach of eligible families and to assist the families in completing the CMSIP application. One rural project has established seven depot stations located at various sites such as a church and a library within a three-county area. At a large metropolitan pilot, participation commitments are being acquired from the administration of the seven metro school districts.
	Distribute information and applications to parents of school-aged children and pre-school children	Data Sources: *Administrative records of outreach campaign* Methodology: *Strategies tracked in outreach campaign* Progress Summary: *A total of 1898 VCMSIP packets were distributed to all school principals along with a letter of support from the Superintendent of schools and the Governor. A total of 1.4 million copies of CMSIP applications were distributed to the*

Table 1.3		
		schools. All licensed and temporary day care facilities received CMSIP information. Also Head Start organizations.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
To Improve the Health Care Status of Children	*Increase the Number of Children with a Usual Source of Care*	Data Sources: *1999 Child Health Access survey; forthcoming Consumer Assessment of Health Plans Survey (CAHPS)* Methodology: *1999 survey provides a statewide benchmark of children with a usual source of care. CAHPS addresses Medicaid enrolled children* Numerator: *CAHPS participants by coverage plan* Denominator: *1999 statewide estimates* Progress Summary: *CAHPS survey results are expected by the end of 2000*
	Increase the Percentage of Children with Immunizations	Data Sources: *DMAS and Virginia Department of Health* Methodology: *Children under age of 3* Numerator: *Children receiving immunizations* Denominator: *Total children to receive immunizations* Progress Summary: *The study report is being drafted by a contractor. The results will be reported for the Medicaid population overall, by program, and the HMO plan level.*

Table 1.3		
	Increase the Number of Children Treated for Asthma	Data Sources: *DMAS encounter and claims data* Methodology: *Tabulation of statistical measures for analyzing childhood asthma such as ER visits/1000; hospital discharges/1000; hospital days./1000 and average hospital length of stay* Progress Summary: *The project design is currently in development.*

Note: In the June 1998 Title XXI application for Virginia, in section 9.3 the boxes were mislabeled. They should read Strategic Objective 1- Reduce Number of Uninsured Children; Strategic Objective 2- Improve the Health Status of Children; and Strategic Objective 3- Conduct Effective Outreach to Encourage Enrollment in Health Insurance Plans.

Table 3.1.1 VIRGINIA CMSIP TITLE XXI PROGRAM			
	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))		*Statewide*	
Age		*0-18 years*	
Income (define countable income)		*Component 1 – 0-150% FPL* *Component 2- 150-185% FPL*	
Resources (including any standards relating to spend downs and disposition of resources)		*Resources are not considered*	
Residency requirements		*Same as Medicaid residency rules for Virginia, 42 CFR 435.403*	
Disability status		*N/A*	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))		*May not be covered at time of application*	
Other standards (identify and describe)		*May not have been covered under group health plan or health insurance for twelve months prior to application (unless demonstrating "good cause")*	

Table 3.1.2 VIRGINIA CMSIP TITLE XXI PROGRAM			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months		*X (Although redetermination will be made earlier if changes reported by parent) – requires resubmission of health information, income, and day care data*	
Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Table 3.2.1 CHIP Program Type_____ VIRGINIA CMSIP TITLE XXI PROGRAM _____			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify) No initial cost sharing in any categories although there is flexibility in the plan for one	Benefit Limits (Specify)
Inpatient hospital services	***T***		*Hospital admissions must be preauthorized, except for emergency admissions, which must be authorized with 24 hours of admission. See State Child Health Plan 6.2.1 (Sections A-H)*
Emergency hospital services	***T***		*Pays for treatment and transportation. See State Child Health Plan 6.2.2 (Section D)*
Outpatient hospital services	***T***		*Pays for outpatient hospital services that allow one to return home the same day after medical care is rendered. See State Child Health Plan 6.2.2 (Sections A-E)*
Physician services	***T***		*Covers physician's services both in the hospital and in the doctor's office. Most visits to the physician's office are not limited, however, a referral is needed to see someone other than PCP. See State Child Health Plan 6.2.3 (Section A-G)*
Clinic services	***T***		*When provided in local Health Departments or other clinics licensed by Virginia. See State Child Health Plan 6.2.5*
Prescription drugs	***T***		*When ordered by a physician and on the CMSIP formulary – see State Child Health Plan 6.2.6*
Over-the-counter medications	***T***		*When ordered by a physician and approved by DMAS – see State Child Health Plan 6.2.7*
Outpatient laboratory and radiology services	***T***		*Must be ordered or prescribed and directed for performed within the scope of a licensed practitioner – see State Child Health Plan 6.2.8*
Prenatal care	***T***		*Pregnancy-related and post-partum services including expanded prenatal services – see State Child Health Plan 6.2.9 (Section B)*
Family planning services	***T***		*Includes drugs, supplies, and devices provided under supervision of a physician; does not include fertility treatments. See State Child Health Plan 6.2.9 (Section A)*
Inpatient mental health services	***T***		*Covered if received in general acute hospitals. A free-standing psychiatric hospital is an Institution for Mental Diseases (IMD) and services offered in an IMD are prohibited because children who are inpatients of IMDs are not eligible for CMSIP. See State Child Health Plan 6.2.10 and State Child Health Plan 6.2.18*
Outpatient mental health services	***T***		*Provided by DMAS enrolled mental health professional – see State Child Health Plan 6.2.11 and State Child Health Plan 6.2.19*

Inpatient substance abuse treatment services	***T***		*For pregnant women – see State Child Health Plan 6.2.18*
Residential substance abuse treatment services	***T***		*For pregnant women; one course of treatment in a lifetime. The institution may not be an IMD. See State Child Health Plan 6.2.18*
Outpatient substance abuse treatment services	***T***		*Group and individual counseling, limited to 26 sessions annually, although additional sessions available if medically necessary. See State Child Health Plan 6.2.19*
Durable medical equipment	***T***		*For use in home and ordered by a physician. Some equipment and supplies must be preauthorized. See State Child Health Plan 6.2.12*
Disposable medical supplies	***T***		*All suitable supplies for home use – some limitations. See State Child Health Plan 6.2.13*
Preventive dental services	***T***		*Preventive and Emergency, see State Child Health Plan 6.2.17 (Sections A and E) and State Child Health Plan 6.2.28*
Restorative dental services	***T***		*Orthodontia, crowns, etc. when prescribed by a dentist and authorized by DMAS. See State Child Health Plan 6.2.17 (Sections A, B, C, and F)*
Hearing screening	***T***		*Part of Early and Periodic Screening, Diagnosis, and Treatment Services. See State Child Health Plan 6.2.28*
Hearing aids	***T***		*Yes, see State Child Health Plan 6.2.12*
Vision screening	***T***		*Part of Early and Periodic Screening, Diagnosis, and Treatment Services. See State Child Health Plan 6.2.24 (Section C) and State Child Health Plan 6.2.28*
Corrective lenses (including eyeglasses)	***T***		*Yes, see State Child Health Plan 6.2.12*
Developmental assessment	*T*		*Part of Early and Periodic Screening, Diagnosis, and Treatment Services. See State Child Health Plan 6.2.28*
Immunizations	*T*		*Part of Early and Periodic Screening, Diagnosis, and Treatment Services. See State Child Health Plan 6.2.3*
Well-baby visits	*T*		*Part of Early and Periodic Screening, Diagnosis, and Treatment Services. See State Child Health Plan 6.2.3*
Well-child visits	*T*		*Part of Early and Periodic Screening, Diagnosis, and Treatment Services. See State Child Health Plan 6.2.3*
Physical therapy	***T***		*Yes, seeState Child Health Plan 6.2.22 (Sections A and B)*
Speech therapy	***T***		*Yes, see State Child Health Plan 6.2.22 (Sections A and D)*
Occupational therapy	***T***		*Yes, see State Child Health Plan 6.2.22 (Sections A and C)*
Physical rehabilitation services	***T***		*Intensive services must be preauthorized, see State Child Health Plan 6.2.24 (Section A)*

Podiatric services	***T***		*Limited to medically necessary; routine and preventive foot care not covered. See State Child Health Plan 6.2.24 (Section D)*
Chiropractic services	*F*		*Not covered in Medicaid benefits*
Medical transportation	***T***		*For both emergency and nonemergency services; may require preauthorization for some nonemergency. See State Child Health Plan 6.2.26*
Home health services	***T***		*Provided by Home Health Agency or registered nurse, up to 32 visits/year unless approved by DMAS. See State Child Health Plan 6.2.14 (Sections A and B)*
Nursing facility	***T***		*Other than IMD. See State Child Health Plan 6.2.24 (Section E)*
ICF/MR	*T*		*Other than IMD. See State Child Health Plan 6.2.24 (Section E); mental retardation waiver services not covered*
Hospice care	***T***		*In certified CMSIP-enrolled hospices, see State Child Health Plan 6.2.23 (Sections A-D)*
Private duty nursing	*F*		*Not covered*
Personal care services	*T*		*Provided by Home Health Agency or registered nurse, up to 32 visits/year unless approved by DMAS. See State Child Health Plan 6.2.14*
Habilitative services	*?*		*Some community mental health and nursing services, see State Child Health Plan 6.2.24*
Case management/Care coordination	***T***		*Targeted case management for high risk pregnant women and infants up to age 2; individuals with mental retardation; children and youth with or at risk for serious emotional disturbances. See State Child Health Plan 6.2.20*
Non-emergency transportation	***T***		*Yes, with preauthorization in some cases. See State Child Health Plan 6.2.26*
Interpreter services	*F*		*Not covered, see State Child Health Plan 6.2.27*
Community Mental Health Services	*F*		*Offered through local Community Services Boards. Mental retardation waiver services are not covered under CMSIP. See State Plan 6.2.11.*
Organ Transplants	*T*		*Corneas, kidneys, livers, heart, and bone marrow are covered. DMAS must preauthorize all except corneas. See State Plan 6.2.1.*
Other (Specify)			

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	___ Yes ___ No	____ Yes x No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	*x* Yes __ No	___ Yes ___ No
Number of MCOs		*Seven MCOs*	
B. Primary care case management (PCCM) program		*x* Yes __ No	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)		___ Yes *x* No	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)		*school-based health services such as physical therapy;hospice; mental health, mental retardation, and substance abuse services*	
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____
Premiums		*N/A*	
Enrollment fee		*N/A*	
Deductibles		*N/A*	
Coinsurance/copayments**		*N/A*	
Other (specify) _____		*N/A*	

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

**See Table 3.2.1 for detailed information.

Table 3.4.1 **What Client Education and Outreach Approaches Does Your CHIP Program Use?**						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards			*T*	*3*		
Brochures/flyers			*T*	*5*		
Direct mail by State/enrollment broker/administrative contractor			*T*	*3*		
Education sessions			*T*	*3*		
Home visits by State/enrollment broker/administrative contractor			*T*	*4*		
Hotline			*T*	*4*		
Incentives for education/outreach staff			*T*	*4*		
Incentives for enrollees			*T*	*4*		
Incentives for insurance agents			*T*	*3*		
Non-traditional hours for application intake			*T*	*4*		
Prime-time TV advertisements			*T*	*3*		
Public access cable TV			*T*	*3*		
Public transportation ads			*T*	*4*		
Radio/newspaper/TV advertisement and PSAs			*T*	*3*		
Signs/posters			*T*	*3*		
State/broker initiated phone calls			*T*	*data unavailable*		

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

Table 3.4.2 Where Does Your CHIP Program Conduct Client Education and Outreach?

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*_____	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters			*T*	*data unavailable*		
Community sponsored events			*T*	*4*		
Beneficiary's home			*T*	*4*		
Day care centers			*T*	*4*		
Faith communities			*T*	*4*		
Fast food restaurants			*T*	*3*		
Grocery stores			*T*	*3*		
Homeless shelters			*T*	*data unavailable*		
Job training centers			*T*	*4*		
Laundromats			*T*	*data unavailable*		
Libraries			*T*	*data unavailable*		
Local/community health centers			*T*	*5*		
Point of service/provider locations			*T*	*4*		
Public meetings/health fairs			*T*	*3*		
Public housing			*T*	*data unavailable*		
Refugee resettlement programs			*T*	*3*		
Schools/adult education sites			*T*	*5*		
Senior centers			*T*	*4*		

Social service agency			*T*	*4*		
Workplace			*T*	*4*		
Other (specify)						
Other (specify)						

and choose “column”.

Table 3.5 VIRGINIA CMSIP TITLE XXI PROGRAM
Coordination with other State Public and Private Programs

Type of coordination	Medicaid*	Maternal and child health	Public/Teaching Hospital Indigent Care Clinics	VDH Children's Specialty Services	School-based programs including Head Start	Community-based organizations (United Way, Boys & Girls Clubs, etc.)	Local Gov't Programs (e.g., Free Clinics, CHCs, FQCHCs)
Administration	*x*						
Outreach*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Eligibility ~~determination~~ form assistance	*x*		*x*	*x*	*x*	*x*	*x*
Service delivery	*x*	*x*	*x*	*x*	*x*		*x*
Procurement	*x*						
Contracting	*x*						
Data collection	*x*						
Quality assurance	*x, see Tables 4.4.1 and 4.4.2*						
Other (specify)							
Other (specify)							

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

TABLE 4.1.1 - A1*

Table 4.1.1 CHIP Program Type VIRGINIA CMSIP TITLE XXI PROGRAM						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children		*13367*		*8.7*		*3671*
Age						
Under 1		*366*				*111*
1-5		*2518*				*721*
6-12		*7042*				*1886*
13-18		*3441*				*953*
Countable Income Level*						
At or below 150% FPL		*9084*				*2644*
Above 150% FPL		*4283*				*1027*
Age and Income						
Under 1						
At or below 150% FPL		*151*				*50*
Above 150% FPL		*215*				*61*

1-5						
At or below 150% FPL		*1175*				*372*
Above 150% FPL		*1343*				*349*
6-12						
At or below 150% FPL		*5220*				*1500*
Above 150% FPL		*1822*				*386*
13-18						
At or below 150% FPL		*2538*				*722*
Above 150% FPL		*903*				*231*
Type of plan						
Fee-for-service		*10023*		*9.08*		*2130*
Managed care		*949*		*8.03*		*378*
PCCM		*2395*		*9*		*1163*

Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly *Report instructions for further details.*

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

Table 4.2.3 VIRGINIA CMSIP PROGRAM						
Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program Virginia Title XXI Program		Other CHIP Program* _____	
	Number of disenroll	Percent of total	Number of disenrollees	Percent of total	Number of disenroll	Percent of total
Reason (Code Number in VA MMIS) TOTAL			3085	100.0%		
Death			*3*	*0.1*		
No longer Virginia resident			*53*	*1.7*		
No longer meets non-financial requirements			*521*	*16.9*		
Local agency unable to locate			*19*	*0.6*		
No longer meets financial eligibility			*990*	*32.1*		
Coverage added in error or temporary cancellation to allow adding other coverage			*81*	*2.6*		
Medicaid card returned to DMAS' fiscal agent			*306*	*9.9*		
Child's maximum age reached			*66*	*2.1*		
Expiration of type-4 coverage			*135*	*4.4*		
CMSIP – Eligible for state employee health coverage			*3*	*0.1*		
CMSIP – Failure to assign rights or pursue 3rd party payments			*19*	*0.6*		
CMSIP – Enrolled with creditable TPL coverage			*369*	*11.9*		
Computer cancellation because the eligibility worker changed the program designation			*520*	*16.9*		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Table 4.3.1 CHIP Program Type _____				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		*$7,550,140*		*$4,992,151*
Premiums for private health insurance (net of cost-sharing offsets)*		*$825,038*		*$545,515*
Fee-for-service expenditures (subtotal)				
Inpatient hospital services		*$1,478,978*		*$977,900*
Inpatient mental health facility services		*$0*		*$0*
Nursing care services		*$8,186*		*$5,412*
Physician and surgical services		*$1,224,291*		*$809,501*
Outpatient hospital services		*$791,413*		*$523,282*
Outpatient mental health facility services		*$185,737*		*$122,810*
Prescribed drugs		*$1,018,356*		*$673,377*
Dental services		*$708,132*		*$468,217*
Vision services		*$103,761*		*$68,606*
Other practitioners' services		*$55,133*		*$36,453*
Clinic services		*$177,025*		*$117,049*

Therapy and rehabilitation services		*$131,308*		*$86,821*
Laboratory and radiological services		*$95,412*		*$63,086*
Durable and disposable medical equipment		*$49,439*		*$32,690*
Family planning		*$0*		*$0*
Abortions		*$0*		*$0*
Screening services		*$150,963*		*$99,817*
Home health		*$8,119*		*$5,368*
Home and community-based services		*$0*		*$0*
Hospice		*$0*		*$0*
Medical transportation		*$18,578*		*$12,284*
Case management		*$59,131*		*$39,097*
Other services		*$0*		*$0*

Note: Table reflects date of payment.

Source: HCFA-21 quarterly report.

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach				*0**		
Administration				*$224,689*		
Other_____				*0*		
Federal share						
Outreach				*0**		
Administration				*$148,564*		
Other __ _____				*0*		

** Outreach included under Administration.* *The Department of Social Services is spending the largest portion of the administrative expenses. This is for activities such as outreach and eligibility determination. DMAS has paid most of its administrative expenditures from State funds to manage within the 10% cap on administrative expenses. DMAS plans to reimburse the Department of Social Services its matching federal funds after it has been determined that they will not exceed the 10% cap. DMAS has received expenditure billings from DSS for FFY99 of approximately $1,267,000.*

Note: Table reflects date of payment.
Source: HCFA-21 quarterly report.

Table 4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees.			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program *(PCCM=Primary Care Case Management, MCO=Managed Care Organization)*	Other CHIP Program* _____
Appointment audits		*recipient surveys (PCCM,MCO)*	
PCP/enrollee ratios		*network capacity reports (MCO)*	
Time/distance standards		*network capacity such as in an urban area 2 PCPs within 15 miles and 30 minutes travel, CAPHS survey (MCO)*	
Urgent/routine care access standards		*standards for urgent and routine care, such as urgent care to be seen same day (MCO)*	
Network capacity reviews (rural providers, safety net providers, specialty mix)		*MCOs must demonstrate adequate network capacity to ensure accessible services; DMAS enrollment broker produces quarterly capacity reports; DMAS contractor analyzes hospital and provider networks; DMAS also monitors networks for the inclusion of general and specialty providers (MCO,PCCM)*	
Complaint/grievance/ disenrollment reviews		*HMOs and DMAS track complaints (all delivery models), DMAS contracts with HMOs state that complaints, grievances and appeals must be integrated with HMO quality improvement plan, DMAS receives monthly complaints reports from enrollment broker, HMOs and Virginia Department of Health; enrollment broker tracks disenrollment (MCO)*	

Case file reviews		*for encounter data validation (MCO)*	
Beneficiary surveys		*household survey of parents of children enrolled in CMSIP addressing satisfaction with providers and plans, access to care, travel time; recipient surveys (MCO)*	
Utilization analysis (emergency room use, preventive care use)		*immunization and prenatal studies (all delivery models) in process, pediatric asthma and children with special needs analysis to be developed; DMAS Surveillance and Utilization Review Subsytem will assess that primary care practitioners are meeting contractual obligations such as under EPSDT (PCCM); general SURS applications (PCCM, fee-for-service)*	
Other (specify); Medallion II waiver assessment		*this is an independent assessment of the Medallion II waiver which includes quality measures for the FFY99 period*	
Other (specify): DMAS Analysis of Terminations		*DMAS analyzes two categories of termination. The first is disenrollments which is a plan change in the first 60 days of enrollment or during open enrollment during February and March. The second category is for good-cause which is in the twelve month lock-in period. good-cause transfers. Reports are produced on each plan a recipient is exiting the one they are moving to along with the reason. Access issues are followed-up.*	

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Table 4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	_x__ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Table 4.5.1 How are you measuring the quality of care received by CHIP enrollees			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program *(PCCM=Primary Care Case Management, MCO=Managed Care Organization)*	Other CHIP Program
Focused studies (specify)		*immunization and prenatal studies in process (all delivery models), pediatric asthma and children with special needs analysis to be developed; DMAS Surveillance and Utilization Review Subsystem will assess that primary care practitioners are meeting contractual obligations such as under EPSDT (PCCM)*	
Client satisfaction surveys		*household survey of parents of children enrolled in CMSIP addressing satisfaction with providers and plans, access to care, travel time; representative samples drawn by contractor of adults and children (PCCM, MCO)*	
Complaint/grievance/ disenrollment reviews		*HMOs and DMAS track complaints (all delivery models), DMAS contracts with HMOs state that complaints, grievances and appeals must be integrated with HMO quality improvement plan, DMAS receives monthly complaints reports from enrollment broker, HMOs and Virginia Department of Health, enrollment broker tracks disenrollment with reports to DMAS (MCO)*	
Plan site visits		*annual visits made (MCO)*	
Case file reviews		*for encounter data validation (MCO)*	
Independent peer review		*for focussed studies, client satisfaction surveys, case file reviews (PCCM, MCO)*	
HEDIS performance measurement		*encounter data currently being analyzed for completeness, eventually will be used for some HEDIS measures. Data will be used for comparisons with PCCM and fee-for-service (all delivery models)*	

Other (specify): HMO Quality Assurance Committee		*HMOs must submit their Quality Improvement Plan on an annual basis to DMAS. This Plan must contain the quality improvement performance measures that will be tracked, the populations involved, and the results when available. In addition, items must be reported such as NCQA/JCAHO accreditation, methods used to detect under and over utilization, and information on partnership activities to enhance quality and accessibility(MCO)*	
Other (specify) DMAS Quality Assurance Workgroup		*coordinates the quality assurance efforts within DMAS (MCO)*	
Other (specify) Case Managers' Meetings		*quarterly meetings consisting of the Medallion II HMO case managers, Virginia Dept. of Health staff, local health departments, Community Services Boards and providers serving Medicaid recipients (MCO)*	
Other (specify): DMAS HMO Clinical Coordinator		*this person addresses HMO provider and recipient concerns on the subject of HMO decisions regarding utilization management, grievances and complaints directed to DMAS and reviews recipients requests for good cause disenrollments (MCO)*	
Other (specify): Special Needs Liaison		*this DMAS staff collaborates with the Virginia Dept. of health staff, Virginia Dept. of Social Services, Virginia Dept. of Mental Health, Mental Retardation, and Substance Abuse Services, and Dept. of Rehabilitative Services on access and quality issues for the special needs population (all delivery models)*	
Other (specify): Independent Assessment		*the assessment of Medallion II for the 1998-99 waiver year is currently underway. The contractor is performing the assessment following HCFA guidelines to states (MCO)*	

Other (specify): Case Management for Special Needs Populations		*enrollment broker conducts a health needs assessment for new Medallion II recipients in order to facilitate the selection of an HMO and primary care provider. Results of the assessment are forwarded to the HMO in which the recipient enrolls (MCO)*	
Other (specify): Virginia Department of Health		*has quality of care standards for HMOs and issues certificates for HMOs meeting them. Meeting these is a requirement for HMOs. HMOs must have procedures for guaranteeing quality of care (MCO)*	
Other (specify): National Committee for Quality Assurance		*HMOs are to have accreditation from NCQA or a comparable organization (MCO)*	
Other (specify): Bureau of Insurance		*HMOs must be licensed. This office includes a managed care ombudsman (MCO)*	